University of Northern Iowa
Student Accessibility Services

Housing & Dining Evaluator Form

INSTRUCTIONS

- **Must be completed and signed by health care professional**
- **Must include descriptive responses in paragraph form**

Student Information

Student Name:	Student ID#:
Student Birthdate:	Type of Accommodation (Housing or Dining):

Americans with Disabilities Act Amendments Act (ADAAA)

An individual with a disability is defined by the ADAAA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.

Healthcare Professional Credentials

Name:	License #:	Licensing State:
Area of Specialization:		
Address:		
City:	State:	Zip:
Phone #:	Fax #:	Email Address:

Disability Assessment

Describe the general nature of your professional relationship with the individual. (ie. primary care, single session to review need for ESA, crisis intervention, ongoing treatment/therapy, etc.)

Does the individual have a diagnosed physical or mental impairment? ☐ Yes ☐ No

If yes, what is the diagnosis?

Does the impairment **substantially** limit any major life activities? ☐ Yes ☐ No

If yes, please describe the major life activities that are limited.

To ensure equal access to their living/dining experience on our campus:

Please state the specific recommendations regarding the accommodation(s) this student needs in their housing assignment and/or meal plan.

Please describe why the accommodation is warranted based on the student's condition(s).

What consequences, if any, may result if the accommodation is not approved?

Release of Information

If clarifying information based on this request were needed, students should also complete a release of information form to enable University staff to speak with their provider(s). Our standard release can be found on the UNI Student Accessibility Services website.

I verify that the accompanying student information is correct, that the student is under my care, and that I am not a relative of the student.

Signature of Healthcare Professional:	Date: